(ii) the category of cost for which an administrative adjustment is sought is not included in the Base Year cost;

(iii) the amount requested is greater than one percent (1%) of the hospital's total patient care costs; items equaling one tenth of one percent (.1%)may be grouped together;

(iv) the adjustment is necessary for the appropriate provision of services. A cost will be considered necessary only if it can be demonstrated that such costs cannot be met through efficient management and economic operation at the existing reimbursable cost level.

c. Requests for an administrative adjustment must be accompanied by full and complete documentation of the request.

d. A non-State-Owned Chronic/Rehabilitation Hospital must begin to expend the costs for which it has received approval within 60 days of the request. If the expenditure does not begin within 60 days the hospital must make notification and those costs will be deducted from the current year rates.

e. An administrative adjustment will not be allowed for the following types of costs.

(i) a cost increase which results from or is attributable to a hospital's voluntary business decision;

(ii) an increase in the cost of doing business which effects the industry as a whole;

(iii) costs incurred to correct DPH or JCAHO deficiencies; and

(iv) costs which fall within a category encompassed by an inflation factor.

f. The following are grounds for an administrative adjustment:

(i) Mechanical Error. An adjustment will be calculated if it is documented that there was a mechanical error in the calculation the of the hospital's inpatient per diem.

(ii) New Governmental Requirements. Statutory or regulatory requirements of a governmental unit or federal



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government which generate a substantial increase in allowable costs as adjusted pursuant to Section III.A. of this plan amendment. An increase in existing governmental requirements will not be considered to be a new governmental requirement.

(iii) Disaster Losses. Costs generated by disaster losses in excess of insurance or extraordinary costs related to disaster losses not covered by outside sources. Documentation shall include verification of loss or extraordinary cost and the insurance or outside source payment. If, however, the loss or extraordinary cost is caused by a facility being inadequately insured according to the standards of the hospital industry, or through negligence on the part of hospital management, such losses or costs shall not be approved.

(iv) DON Operating Costs. A hospital has incurred or expects to incur an increase in operating costs associated with a major capital expenditure or substantial change in services which is subject to and has received a determination of need pursuant to M.G.L. c. 111, ss. 25B - 25G. In its request the hospital must segregate the increased costs from other allowed operating costs and must demonstrate that the increased costs requested are reasonable.

(v) Wage Parity. An adjustment may be allowed for costs for reasonable increases in direct care staff salaries and wages in excess of the amount allowed through inflation. This adjustment will not exceed actual rate year expenditures for such increases.

(a) Wage relief may be requested for technicians, nurses, nursing aides, orderlies, attendants, occupational, speech, recreational,physical and/or respiratory therapists. Personnel in each of these categories whose primary job functions are administrative and not directly involved in the delivery of patient care are not eligible for wage relief under this exception.

(b) The adjustment is as follows: direct care staff salaries and wages is defined as the reasonable rate year wage rate less the inflated base year wage rate, time the lesser of the rate year FTE direct care labor force or the base year FTE direct care labor force. The reasonable rate year wage will be the level of increase required to attract sufficient staff to ensure minimum quality of care as

determined by the DPH of Public health for current patients. The rate will be determined with reference to average rates prevailing at other hospitals with in the same Medicare labor market region, subject to the following conditions:

(1) Outlier wage rates as defined by the DHCFP shall be excluded from the computation;

(2) Special weight shall be given to rates prevailing at nonacute hospitals located in the hospital's Medicare labor market region;

(3) In no case shall the reasonable rate year wage rate used in this calculation exceed the wage rate actually prevailing at hospitals located in the hospital's Medicare labor market region at the time of application.

(4) The determined Medicare Labor Market Regions and their associated counties are as follows:

| **Medicare Labor Market Region** | **Counties** |
|---|---|
| Eastern Mass | Bristol |
| | Essex |
| | Middlesex |
| | Norfolk |
| | Plymouth |
| | Suffolk |
| | Worcester |
| Berkshire | Berkshire |
| Springfield | Hampden |
| | Hampshire |
| Barnestable | Nantucket |
| | Barnestable |
| | Dukes |
| Rural | Franklin |

(6) In order to be eligible for this adjustment, a hospital must demonstrate that it is facing extraordinary difficulties in the market for direct care staff, as indicated by one or more of the criteria established in St. 1988, Chapter 270. These criteria include, but are not limited to:

* existence of significant vacancy rates for a period of time sufficient to jeopardize the welfare of patients according to DPH standards, Joint Commission on Accreditation of Hospital standards or other qualifying guidelines utilized in Massachusetts to ensure adequate care;

* persistent difficulty in recruitment given bona fide recruitment efforts to obtain staffing levels;

(vi) Case Mix Intensity. An administrative adjustment may be allowed for an increase in inpatient care costs generated by increased care or services required by a more intensely ill patient population.

(vii) Transfers of Costs. Where a hospital has reduced or increased costs by the transfer of those costs to or from other persons or entities which provide health care and services, the allowable cost may be modified to reflect the change in cost. In order to give effect to a transfer of cost, each hospital must file information concerning the cost, volume and revenue thirty (30) days prior to implementation of a proposed transfer of cost, and must submit any additional information regarding the transfer of costs at that time. An increase (transfer on) or decrease (transfer off) of hospital costs related to persons or entities which provide hospital care or services and which change compensation arrangements from non-hospital cased to hospital based (transfer on) or from hospital based to non-hospital based (transfer off). A transfer on of physician compensation will only be allowed if reasonable.

**6. Allowable Inpatient Rate For New Hospitals and Hospitals Which Closed a Majority of Beds and Now Provide Some Services in a New Location under New Management.**

a. Base Year. For new hospitals which were not licensed and/or operated



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as non-State-Owned Chronic/Rehabilitation Hospitals in FY 1993, or which did not report a full year of actual costs in FY 1993, the base year for operating and capital costs will be the first cost reporting period of at least twelve months after the hospital is licensed and/or operated as a non-State-Owned Chronic/Rehabilitation Hospital. For hospitals licensed and/or operated as a non-State-Owned Chronic/Rehabilitation Hospital in FY 1993 but which eliminated a majority of beds and closed the facility and which in subsequent years continued to provide some services in a new location and under new management, the base year is the first cost reporting period of at lease twelve months after the hospital started to provide the service at the new location.

b. The Allowable Inpatient Rate will be determined using the methodology set forth in III. A. 2., Allowable Base Year Inpatient Costs of this plan amendment substituting the hospital's base year for FY 1993.

(i) Each efficiency standard will be inflated to the hospital's base year using an inflation factor calculated in accordance with III A. 2. d. (ii), Inflation of this plan amendment.

(ii) Base year operating costs which are not subject to efficiency standards will be evaluated for reasonableness. Criteria for such review will include peer group analysis of costs incurred by comparable facilities.

c. For each new hospital for which a base year has not yet been determined and whose operating costs are not subject to the efficiency standards will have the their projected operating and capital costs evaluated for reasonableness through peer group analysis of costs incurred by comparable facilities.

**7. Rates of Payment for Administrative Days.** The method of payment for services provided to administrative day patients is as follows:

Inpatient services furnished to administrative day patients are paid at the lesser of $113.27 per patient day or the Inpatient Rate.

## IV. PAYMENT ADJUSTMENT FOR DISPROPORTIONATE SHARE HOSPITALS

None of the non-State-Owned Chronic/Rehabilitation Hospitals in the Commonwealth offer obstetric services. In accordance with Section 1923 of the Social Security Act (42 U.S.C. 1396r-4), the Commonwealth will make payment adjustments to nonacute hospitals which serve a disproportionate number of low-income patients. Eligibility



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requirements and the methodology for calculating the adjustment are described below.



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**IVA. Determination of Eligibility**

A non-State-Owned Chronic/Rehabilitation Hospital is eligible for a disproportionate-share adjustment if:

1. the hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state; or

2. the hospital's low-income utilization rate exceeds twenty-five percent (25%) and,

3. to qualify for any type of disproportionate payment adjustment, a hospital must have a Medicaid inpatient utilization rate, calculated by dividing Medicaid patient days by total patient days, of not less than one percent (1%).

**IVB. Payment Adjustment**

1. The total of all disproportionate share payments awarded to a particular hospital under this section shall not exceed the costs incurred during the year of furnishing hospital services to individuals who either are eligible for Medicaid or have no health insurance or source of third party coverage, less payments by Medicaid and by uninsured patients. No hospital will be paid more than the sum of Medicaid unreimbursed costs and free care of that hospital. If an audit reveals that payments in any rate year exceed this sum for a particular hospital, the excess payments would be returned or offset against disproportionate share payments to the hospital for subsequent rate years.

    a. The total amount of funds allocated for payment to Nonacute hospitals including Chronic/Rehabilitation, Psychiatric and State-Owned Nonacute hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement shall be $150,000 per year.

2. The total amount of funds to be allocated for each year will be distributed amongst the qualifying non-State-Owned Chronic/Rehabilitation Hospitals for that year, in accordance with the determination of eligibility described in Section IV. A. above. The distribution of these funds will be made according to the following methodology: For each hospital which qualifies under 1.a. above:

    a. the relative ratio of a hospital's Medicaid inpatient utilization rate to one standard deviation of the mean Medicaid inpatient rate for hospitals receiving Medicaid payments in the state will be calculated;

    b. a non-State-Owned Chronic/Rehabilitation Hospital's relative ratio as determined above will be multiplied by a base amount in order to



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determine the payment adjustment amount for that nonacute hospital. The base amount shall be calculated such that the distribution of funds among qualifying hospitals under Section IV.A. above, shall equal the amount specified in Section IV.B.1.a.

Example: The mean Medicaid inpatient utilization rate in the state is 0.45 with a standard deviation (std) of .07. No hospital shall be eligible unless the criterion set forth in section IV A. above are met.

| (A) Qualifying Hospitals | (B) Medicaid Inp. Util. Rate | (C)** Ratio of Hosp. Med. Util. Rate to Mean plus std* | Payment Adjustment |
|---|---|---|---|
| A | 0.55 | 1.0577 | 10,275.02 |
| B | 0.60 | 1.1538 | 11,208.58 |
| C | 0.69 | 1.3270 | 12,891.13 |
| D | 0.71 | 1.3654 | 13,264.16 |
| | | TOTAL: | $47,638.89 |

* Mean (0.45) + std (.07) = 0.52.

** FY 1989 base amount equals $8,468.98; FY 1990 base amount equals $16,937.96; FY 1991 base amount equals $25,406.94 FY 1992 base amount equals $14,571.74; FY 93 base amount equals $9,714.49

o for each hospital which qualifies under IV.A.(2) but not IV.A.(1) above:

A base amount of the total allocated amount specified in a. above, plus an additional amount, calculated on the base and proportionate to the amount that such hospital's low income utilization rate exceeds twenty-five percent, shall be determined.

Example: Five hospitals' low-income utilization rates are at or above 25% and such hospitals do not qualify under IV.A.(1) above. One hospital's low income utilization rate is 25%, while the rest exceed the 25% rate.

| (1) Qualifying Hospitals | (2) Low Income Util. Rate | (3) Ratio of Low Inc. Util. Rate | (4) Payment Adjustment* |
|---|---|---|---|
| A | .25 | 1.00 | $14,571.74 |
| B | .26 | 1.01 | 14,717.45 |

| | | | |
|---|---|---|---|
| C | .31 | 1.06 | 15,446.04 |
| D | .40 | 1.15 | 16,757.50 |
| E | .42 | 1.17 | 17,048.93 |
| | | | $78,546.66 |

* FY 1992 base amount equals $14,571.74

** Total for hospitals qualifying under either IV.A.(1) or (2) equals $150,000 as specified in IV.B.1.a. If the hospital qualifies under both criteria no additional payment is make beyond what the hospital receives pursuant to the first criterion.

**IV.C. Pediatric Outlier: For Infants Under One Year of Age**

1. In accordance with section 1902 of the Social Security Act, as amended by Section 4604 of OBRA 90, effective July 1, 1991, the Commonwealth will make an annual payment adjustment to non-State-Owned Chronic/ Rehabilitation Hospitals for inpatient hospital services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths of stay.

2. Determination of Eligibility. Determination of eligibility for infants under one year of act shall be made as follows:

   a. Exceptionally long lengths of stay.

      (i) First calculate the statewide weighted average Medicaid inpatient length-of-stay. This shall be determined by dividing the sum of Medicaid days for all non-State-Owned Chronic/Rehabilitation Hospitals in the state.

      (ii) Second, calculate the statewide weighted standard deviation for Medicaid inpatient length-of-stay statistics.

      (iii) Third, add one and one-half times the state wide weighted standard deviation for Medicaid inpatient length-of-stay to the state wide weighted average Medicaid inpatient length-of-stay. Any stay equal to or lengthier than the sum of these two numbers shall constitute and exceptionally long length-of-stay for purposes of payment adjustments under this section.

   b. Exceptionally High Cost. For each non-State-Owned Chronic/Rehabilitation Hospital providing services on or after July 1, 1991 to individuals under one year of age the Commonwealth shall:

      (i) First, calculate the average cost per Medicaid inpatient



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discharge for each hospital;

(ii) Second, calculate the standard deviation for the cost per Medicaid inpatient discharge for each hospital;

(iii) Third, add one and one-half times the hospital's standard deviation for the cost per Medicaid inpatient discharge to the hospital's average cost per Medicaid inpatient discharge. Any cost which equals or exceeds the sum of these two numbers shall constitute an exceptionally high cost for purposes of payment adjustments.

(a) The amount of funds allocated shall be twenty five thousand dollars ($ 25,000) for FY 1996. This includes Chronic/Rehabilitation, Psychiatric and State-Owned Nonacute hospitals.

(b) Any Hospital which qualifies for a payment adjustment for infants under one shall receive one percent of the total funds allocated for such payments. In the event that the payments to qualifying non-State-Owned Chronic/Rehabilitation Hospitals would exceed the total, each share shall be proportionately reduced to stay within the allocation.

**IV.D. Children Under Six**

1. Eligibility for Payment. Consistent with section 4604 of the Omnibus Reconciliation Act of 1990 (OBRA 90) outlier adjustments for medically necessary inpatient hospital services, effective July 1, 1991, involving exceptionally high costs or exceptionally long lengths of stay (as defined in sections IV.C. 2a. and 2b. of this Plan), are extended to services for children who have not reached the age of six, if provided by a hospital which qualifies as a disproportionate share hospital under Section 1923 (a) of the Social Security Act.

2. Amount of Payment Adjustment

   a. The amount of funds allocated shall be twenty five thousand dollars ($ 25,000) for FY 1996. This includes Chronic/Rehabilitation, Psychiatric and State-Owned Nonacute hospitals

   b. Any Hospital which qualifies for a payment adjustment for children under six, pursuant to IV.C.1. above shall receive one percent of the total funds allocated for such payments. In the event that the payments to



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qualifying non-State-Owned Chronic/Rehabilitation Hospitals would exceed the total, each share shall be proportionately reduced to stay within the allocation.

(Intentionally deleted)

## V. OTHER ADMINISTRATIVE ADJUSTMENTS

### V.A. Administrative Review

1. Purpose of Administrative Review. Whenever information is received form any source indicating that a provider's rate may be based upon inaccurate or outdated information, the DHCFP may initiate an administrative review to determine if a rate reduction is warranted. The reasons for which the DHCFP may initiate the review include: to insure that costs included in the rate were actually incurred; to insure that costs were properly reported, or to determine whether a rate should be adjusted to reflect a major change in services occurred after the base year.

2. Notice of Administrative Review. The DHCFP may at any time review the rate upon notice to the hospital. The commission shall initiate administrative review by notifying the hospital that it intends to conduct an administrative review. The notification shall be in writing and shall include a statement of the reason for review.

3. Request for Information. The DHCFP may request that the provider submit books, records, and any other necessary information.



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4. Results of Administrative Review. After review, the DHCFP will issue a written decision and a statement of reasons for its decision.

**V.B. Appeal**

A hospital which is aggrieved by an action or failure to act by the DHCFP under 114.1 CMR 39.00 may file an appeal within thirty (30) days to the Division of Administrative Law Appeals, pursuant to M.G.L. c. 118G. The pendency of an appeal does not limit the DHCFP's right to undertake administrative review of rates.

**The Commonwealth's Budget Reform and Control Act of Chapter 653, Act of 1989, Section 84**

The DMA shall review, and approve or disapprove, any change in rates or in rate methodology proposed by the DHCFP. The DMA shall review such proposed rate changes for consistency with the DMA's policy and federal requirements, and with the available funding authorized in the final budget for each fiscal year prior to certification of such rates by the DHCFP; provided, that the DMA shall not disapprove a rate increase solely based on the availability of funding if the Federal Health Care Finance Administration provides written documentation that federal reimbursement would be denied as a result of said disapproval and said documentation is submitted to the House and Senate Committees on Ways and Means. The DMA shall, whenever it disapproves a rate increase, submit the reasons for disapproval to the DHCFP together with such recommendations for changes. Such disapproval and recommendations for changes, if any, shall be submitted to the DHCFP after the DMA is notified that the DHCFP intends to propose a rate increase for any class of provider under Title XIX but in no event later than the date of the public hearing held by the DHCFP regarding such rate change; provided that no rates shall take effect without the approval of the DMA. The DHCFP and the DMA shall provide documentation on the reasons for increases in any class of approved rates that exceed the medical component of the consumer price index to the House and Senate Committees on Ways and Means. The DHCFP shall supply the DMA with all statistical information necessary to carry out the DMA's review responsibilities under this Section. Notwithstanding the foregoing, said DMA shall not review, approve, or disapprove any such rate set pursuant to Chapter Twenty- Three of the Acts of Nineteen Hundred and Eighty-Eight.

If projected payments from rates necessary to conform to applicable requirements of Title XIX are estimated by the DMA to exceed the amount of funding appropriated for such purpose in the budget for such fiscal year, the DMA and the DHCFP shall jointly prepare and submit to the Governor a proposal for the minimum amount of supplemental funding necessary to satisfy the requirements of the State Plan developed by the DMA under Title XIX of the Federal Social Security Act.



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